

MDR Tracking Number: M5-04-3952-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-20-04.

The IRO reviewed service for impairment rating rendered on 09-03-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the issue of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-11-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 date of service 09-03-03 denied with a "V" denial code for medical necessity with a peer review. This service is a TWCC required report and will be reviewed as a fee issue. The requestor submitted relevant documentation to support delivery of the service. Reimbursement is recommended in the amount of \$15.00 per the Medical Fee Guideline effective 08-03-03.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for date of service 09-03-03 in this dispute.

This Findings and Decision and Order are hereby issued this 13th day of September 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

MEDICAL REVIEW OF TEXAS

[IRO #5259]

3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3952-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

September 9, 2004

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved

Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available information suggests that this patient reports experiencing a low back injury that occurred while at work on _____. He has gone through extensive conservative care including chiropractic, physical therapy and epidural steroid injections with little improvement documented. Myelogram and post-myelogram CT shows no evidence of HNP, but some evidence of DJD and disc bulging. Electrodiagnostic evaluation is essentially normal but some chronic S1 chronic radiculopathy is suspected. Follow-up CT scan also suggests 3-4mm anterolisthesis of L5 on S1. The patient is seen by Dr. B, MD, for orthopedic assessment and is found L5/S1 discogenic back pain. He has had a lumbar discogram, which showed some L5/S1 discopathy and later underwent IDET procedure with no significant improvement. A designated doctor evaluation is made July 1, 2002 by a Dr. M, DO, placing the patient at MMI with 5% WPI. This is apparently disputed by treating chiropractor as well as Dr. B and another impairment rating evaluation is apparently performed on 09/03/03. Unfortunately, this subsequent impairment rating evaluation is not provided for review.

REQUESTED SERVICE(S)

Determine medical necessity for Impairment Rating (99455).

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

TWCC Medical Fee Guidelines. Medical necessity for 99455 Impairment Rating cannot be determined, as the report for this service is not submitted for review. In addition, \$600.00 charge for this service would suggest that more than one area was assessed. As compensable diagnosis appears to be for lumbar only (one area), medical necessity for this additional level of service cannot be supported.

The observations and impressions noted regarding this case are strictly the opinions of this evaluator. This evaluation has been conducted only on the basis of the medical/chiropractic documentation provided. It is assumed that this data is true, correct, and is the most recent documentation available to the IRO at the time of request. If more information becomes available at a later date, an additional service/report or reconsideration may be requested. Such information may or may not change the opinions rendered in this review. This review and its findings are based solely on submitted materials.

No clinical assessment or physical examination has been made by this office or this physician advisor concerning the above-mentioned individual. These opinions rendered do not constitute per se a recommendation for specific claims or administrative functions to be made or enforced.